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Blueprint Executive Committee Meeting
Minutes
February 16, 2011

Present: C. Benham, D. Cochran, M. Davis, T. Dolan, C. Hindes, C. Jones, S. Kimbell, J. Leddy, C. MacLean, B. Tanzman, S. Williams, D. Wachtel,

Via Conference Line: G. Bjornson, D. Curry, D. George, P. Harrington, R. Hines, W. Little, R. Slusky, N. Wilson, L. Watkins

The meeting opened at 8:35 a.m.

I. ***Update on Expansion***:

- Blueprint statewide expansion target is 2 practices in each HSA by July 2011. We are on track for meeting the July target. The expansion timetable is updated on a weekly basis. The 2010 Blueprint Annual Report lays out the expansion plan through the end of 2011.
- The expansion includes three pediatric practices and we anticipate NCQA scoring for these to take place in March.
- New NCQA Standards were released earlier this month. The new standards reflect more emphasis on Behavioral Health integration and HIT. The Blueprint will follow the NCQA recommended timeframes for use of the new standards and UVM is well prepared to switch to the new scoring standards.
- Unlike the initial three pilot sites, there will be no practice size requirements for future sites to participate in the medical home model.
- Ten (part-time and full-time) Facilitators have been hired for an FTE equivalent of eight. They are each working in their assigned geographic areas focusing on ongoing quality improvement work. Initially Facilitators will help with NCQA preparation for scoring and then going forward they will focus on data-driven practice improvements. Bi-State has also hired a practice facilitator to work with the FQHCs. National information indicates that a good facilitator can work with 10 – 15 practices at a time.
- The intention is for this infrastructure to be durable and for the Facilitators to support data-driven quality improvement. We are moving toward a learning health system with the necessary infrastructure to make ongoing rapid cycle improvements in care.

II. ***Program Evaluation: The Infrastructure***

- The infrastructure for the project evaluation has been built. There are a number of different data sources in use including: the Central Registry, Multi-Payer Claims database, Chart reviews, NCQA scoring, Hospital data (affiliated practices), and Public Health Registries. We now have a maturing infrastructure in place.
- An analytic workgroup has been formed and will be meeting on a monthly basis.
- Health information infrastructure: We are using national guidelines (e.g. for asthma and age appropriate health maintenance) and have created a data to form the connection between practice-level EMRs and the VITL Health Information Exchange (HIE). This allows us to capture data in a way that is useful for outreach to patients, for measurement, and to guide practice. Close to thirty practices and nearly one half of the hospitals are reporting to VITL.
- What we capture is being fed through the data registry. This central registry provides several functions: flexible reporting, visit planners for individual patients, panel reporting for outreach and comparative effectiveness and performance reporting. We will conduct a live registry demonstration at a future meeting of this group.
- We believe we now have a framework on how to build out an HIT model that will truly create a digital infrastructure for a learning health system. Craig Jones and Hunt Blair have laid out a strategy and will be presenting that strategy to the ONC in Washington.
- The IT infrastructure and evaluation process will help answer the question of what really helps improve health outcomes?.
- Our end goal is to build a solid foundation of continuum health services and sustainable payment reform.
- Beth Tanzman is working on the financial modeling for mental health and substance abuse.

III. Program Evaluation: Early Trends

- Dr. Jones sent out a slide set of *Blueprint for Health Early Trends*
- Early trends are described in the 2010 Blueprint Annual Report. You may access the 2010 Report by going to: http://hcr.vermont.gov/blueprint_for_health
- Early utilization trends are pointing in a similar direction from different sources.
- Early trends in the rate of change for hospital inpatient admissions & emergency department visits are detailed beginning on Page 25 of the Annual Report. Initial trends indicate that those who used the CHT's had a greater rate of change (towards reduced use) compared to the general population.
- The data presented only includes patients actually seen in practices since the start of the pilot with a 4 year period look back. This is not a controlled comparison.
- There has been a rapid increase on how practices are using self-management referrals. This may be due in part because of how payment is made.

IV. Other Business:

- We have submitted an AHRQ-Impact Application to become a demonstration site. We will share that application with this group.
- *Jim Leddy referenced a recent article printed in the New Yorker. "*Can we lower Can we lower medical costs by giving the neediest patients better care*? Author: Atul Gawande*

http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande?currentPage=all

V. Public Comment

No members of the public offered comments.

The meeting closed at 10:40 am

The next meeting will be held on:

Wednesday, March 16, 2011
8:30 – 10:00
Montpelier
Large Conference Room
BISHCA